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Issue Date: 28 July 2006

In the Matter of:
MORELLE MULLINS
Claimant

Case No.: 2003 BLA 5495

v.

PLOWBOY COAL CO./
CONTINENTAL INDEMNITY CO.,
Employer/Insurer

and

DIRECTOR, OFFICE OF WORKERS'
COMPENSATION PROGRAMS

Party in Interest

Appearances: Mr. Ron Carson, Representative
For the Claimant

Mr. H. Ashby Dickerson, Attorney
For the Employer/Insurer

Before: Richard T. Stansell-Gamm
Administrative Law Judge

**DECISION AND ORDER ON REMAND –
AWARD OF BENEFITS**

This matter involves a claim filed by Mr. Morelle Mullins for disability benefits under the Black Lung Benefits Act, Title 30, United States Code, Sections 901 to 945 (“the Act”), as implemented by 20 C.F.R. Parts 718 and 725. Benefits are awarded to persons who are totally disabled within the meaning of the Act due to pneumoconiosis, or to survivors of persons who died due to pneumoconiosis. Pneumoconiosis is a dust disease of the lung arising from coal mine employment and is commonly known as “black lung” disease.

On May 17, 2004, essentially based on my interpretation of *Eastern Associated Coal Corp. v. Director, OWCP [Scarbro]*, 220 F.3d 250 (4th Cir. 2000), I determined that Mr. Mullins established: a) the irrebuttable of total disability due to pneumoconiosis due to the presence of

complicated pneumoconiosis; b) a change in a condition of entitlement; and, c) entitlement to black lung disability benefits.

The Employer appealed the award of benefits. On July 8, 2005, the Benefits Review Board (“BRB” and “Board”) determined that I had misinterpreted and misapplied the *Scarbro* decision and committed several other evidentiary errors. As a result, the BRB vacated my award and remanded the case for further adjudication consistent with its determinations.

Procedural Background

In my May 17, 2004 decision, I previously summarized the procedural history of Mr. Mullins’ several claims, including the present fourth claim which he filed in April 2001.

Evidentiary Discussion

Upon its review of my decision, the Benefits Review Board noted both the possible admission of another chest x-ray interpretation and expressed several concerns concerning my prior evidentiary determinations regarding several medical opinions. However, prior to answering the BRB’s concerns, I must address a recent BRB decision which alters the admissibility of the CT scan interpretations in this case.

CT Scans

At the 2003 hearing, as offered by the Claimant, I admitted two CT scan interpretations of an April 2, 2001 chest/thorax CT scan by Dr. Alexander and Dr. DePonte, DX 18, under 20 C.F.R. § 718.107 (a), which governs the admission of “other medical evidence.” At that time, the evidentiary restrictions did not appear to limit evidence submissions under 20 C.F.R. § 718.107 (a). A year later, the Benefits Review Board agreed and determined in *Dempsey v. Sewell Coal Co.*, 23 B.L.R. 1-47 (2004) (en banc) that the regulatory restrictions in 20 C.F.R. § 725.414 do not apply to “other medical evidence” admissible under 20 C.F.R. § 718.107. Additionally, relying on the ability of an employer to respond to each piece of evidence submitted by a claimant, as established by 20 C.F.R. § 725.414 (a) (3) (ii), I admitted two interpretations presented by the Employer of the same CT scan by Dr. Wheeler, EX 2, and Dr. Scott, DX 24.

Recently, the BRB has changed its mind. In *Webber v. Peabody Coal Co.*, 23 B.L.R. 1-___, BRB No. 05-0335 BLA (Jan. 27, 2006) (en banc) (J. Boggs, concurring), now divining the “intent” of the same regulations that had been before them earlier in the *Dempsey* case, the Board concluded the 20 C.F.R. § 725.414 evidentiary restrictions do apply and limit a party to “one” interpretation of a CT scan as part of its affirmative case-in-chief. Similarly, the responding party may offer one interpretation in rebuttal.

At first pass, the new *Webber* CT scan evidence restriction of one interpretation per CT scan appears to require that I exclude one of the two interpretations of the April 2, 2001 CT scan offered by the Claimant. However, upon review I note that Dr. DePonte conducted a CT scan of Mr. Mullins’ chest at the request of his treating physician, Dr. Kanwal, in an effort to evaluate

“advancing” pneumoconiosis. In other words, Dr. DePonte’s CT scan interpretation is part of Mr. Mullins’ treatment record from St. Mary’s Hospital. Under the new regulations, treatment records are placed in a special category. According to 20 C.F.R. § 718.414 (a) (4), regardless of the evidentiary restrictions, “any record of a miner’s . . . medical treatment for a respiratory disease or pulmonary or related disease, may be received into evidence.” *See also Dempsey*, 23 B.L.R. 1-47 (treatment records, containing multiple pulmonary function and blood gas studies that exceed the limitations at § 725.414, are properly admitted). Based on that regulatory language, and in light of the new *Webber* evidentiary limit, Dr. Alexander’s interpretation of the April 2, 2001 CT scan may be admitted as the one permissible case-in-chief interpretation under 20 C.F.R. § 725.414 (a) (2) (i) and Dr. DePonte’s interpretation of the April 2, 2001 CT study is admissible as a treatment record under 20 C.F.R. § 718.414 (a) (4).

Next, turning to consideration of the two interpretations of the April 2, 2001 CT scan provided by the Employer, at least one reading is admissible as proper rebuttal under 20 C.F.R. § 718.414 (a) (3) (ii) to the Claimant’s affirmative case-in-chief interpretation by Dr. Alexander. Arguably, under the notion of due process, the second interpretation could also be admitted as proper rebuttal to Dr. DePonte’s treatment record CT scan interpretation. However, in *Henley v. Cowin & Co.*, BRB No. 05-0788 BLA (May 30, 2006) (unpub.), the BRB determined that the provisions at § 725.414 do not allow for the rebuttal of treatment records.¹ Accordingly, only one of the two interpretations of the April 2, 2001 CT scan submitted by the Employer is admissible as rebuttal. In determining which interpretation to accept, I note that at the hearing Employer’s counsel presented Dr. Wheeler’s evaluation as the principal interpretation for the April 2, 2001 CT scan. Based on that representation, I will consider Dr. Wheeler’s interpretation of the April 2, 2001 CT scan, EX 2, as the Employer’s rebuttal to the Claimant’s case-in-chief CT scan interpretation by Dr. Alexander. At the same time, since rebuttal to Dr. DePonte’s treatment record CT scan interpretation is apparently not permitted by the BRB, I conclude Dr. Scott’s interpretation of the April 2, 2001 CT scan, DX 24, is no longer admissible.

Finally, I turn to the last consideration recently imposed by the BRB concerning CT scans. In *Tapley v. Bethenergy Mines, Inc.*, BRB No. 04-0790 BLA (May 26, 2005) (unpub.), the Board held that, because CT-scans are not covered by specific quality standards under the regulations and based on the language in 20 C.F.R. § 718.107(b), the proffering party bears the burden of demonstrating that the CT-scans were “medically acceptable and relevant to establishing or refuting a claimant’s entitlement to benefits.”

Applying this criteria to Dr. DePonte’s evaluation, I note that this board certified radiologist believed the CT scan procedure was sufficiently “medically acceptable” to permit her to provide an evaluation of Mr. Mullins’ lungs to his treating physician. As to relevancy, Dr. DePonte conducted the CT scan evaluation at Dr. Kanwal’s request to determine whether pneumoconiosis was advancing in Mr. Mullins’ chest. Since that’s the same issue before me, Dr. DePonte’s evaluation is obviously relevant.

¹As a result, the Board vacated the administrative law judge’s ruling that Employer could submit a rebuttal interpretation of a chest x-ray reading contained in the miner’s treatment records.

Next, and for similar reasons, I find Dr. Alexander's CT scan interpretation to be medically acceptable and relevant. Dr. Alexander, a board certified radiologist, apparently believed the CT scan was of sufficient medical acceptability to permit him to render an interpretation. Notably, he expressed no reservation concerning the quality of the radiographic study. Further, his detailed findings are also relevant in this case.

Finally, based on Dr. Wheeler's first line annotation that the CT scan had "good quality lung and mediastinal settings" and in light of his detailed findings regarding the various opacities and masses in Mr. Mullins' lungs, I find his interpretation to be medically acceptable and relevant to Mr. Mullins' black lung disability entitlement claim.

Admissible Chest X-Ray Interpretation

In its critique of my evidentiary analysis of Dr. Smiddy's opinion, CX 5, the Board noted that Dr. Smiddy indicated that he had reviewed the chest x-ray from February 3, 2003 and agreed with Dr. Miller that it showed Category A large opacities and simple pneumoconiosis. Since the Claimant only submitted one, rather than two, affirmative case-in-chief chest x-rays, the Board stated that I "may consider whether Dr. Smiddy's interpretation. . . could be considered claimant's second x-ray reading in accordance with 20 C.F.R. § 725.414 (a) (2)." Upon consideration of Dr. Smiddy's opinion, I will now include his interpretation of the February 3, 2003 chest x-ray as the Claimant's second case-in-chief radiographic study.

Dr. Kanwal

In his April 15, 2002 medical note, DX 25, Dr. Kanwal stated, "Mr. Mullins' X-rays and CT scan have revealed Coal Miner's Pneumoconiosis." In a hand-written annotation, Dr. Kanwal added, "He has developed massive pulmonary fibrosis interstitial."

In my initial decision and order, I noted that since Dr. Kanwal did not identify the specific chest x-rays and CT scan, he may have based his opinion on medical evidence that was inadmissible. Such consideration poses a problem due to the evidentiary restrictions under 20 C.F.R. § 725.414 (a) (2) (i) which states:

[a]ny chest x-ray interpretations, pulmonary function test results, blood gas studies...biopsy report, and physicians' opinions that appear in a medical report must each be admissible under this paragraph or paragraph (a) (4) of this section.

In considering that issue, I noted that Dr. Paranthaman's admissible interpretation of a May 2001 chest x-ray, DX 12, and the interpretations of Dr. Alexander and Dr. DePonte of an April 2001 CT scan, DX 18, predated Dr. Kanwal's statement. Since that admissible evidence would have been available to Dr. Kanwal, I found no violation of the evidentiary limitations.

The BRB disagreed. Finding my determination that Dr. Kanwal had the studies available to him to be "speculative," the Board directed me to reconsider whether Dr. Kanwal's April 2002 report "provides a documented and reasoned opinion that the claimant has complicated

pneumoconiosis.”

At the Board’s direction, I have again reviewed Dr. Kanwal’s report and the three radiographic studies and, based on two factors, find sufficient circumstantial evidence that his opinion is supported by at least one readily identifiable and admissible radiographic report. First, as Dr. Kanwal noted in his April 2002 report, he had been Mr. Mullins’ treating physician since 1994. Second, in her report, DX 18, Dr. DePonte states that she conducted the April 2001 CT scan of Mr. Mullins based on an order by Dr. Kanwal. The stated reason for the CT scan request was “abnormal chest x-ray, advancing pneumoconiosis and fibrosis.” In her study, Dr. DePonte reported observing severe pneumoconiosis with progressive massive fibrosis. I believe Dr. DePonte’s annotations establish that she conducted a CT scan for Mr. Mullins’ treating physician, Dr. Kanwal, and through a reasonable inference, I conclude the CT scan referenced by Dr. Kanwal was Dr. DePonte’s interpretation.

Turning to Dr. Kanwal’s reference to chest x-rays, I have been unable to ascertain whether Dr. Kanwal reviewed Dr. Paranthaman’s earlier positive chest x-ray interpretation or any other admissible chest x-ray interpretation. In that case, the chest x-rays he reviewed were either part of Mr. Mullins’ medical record since Dr. Kanwal is a treating physician or inadmissible. To void a repeated error of “speculation,” I will treat the unidentified chest x-rays as inadmissible.

Since Dr. Kanwal relied in part on inadmissible evidence, and due to the evidentiary restriction noted above, I must next address the admissibility of his medical report. In *Harris v. Old Ben Coal Co.*, 23 B.L.R. 1- ___, BRB No. 04-0812 BLA (Jan. 27, 2006) (en banc), the Benefits Review Board indicated that when confronted with a medical opinion that contained evidence not admitted into the formal record, an administrative law judge may: a) exclude the report; b) redact the objectionable content; c) require a revised report; or, d) consider the physician’s reliance on the inadmissible evidence in deciding the probative value of the report. In the present case, I will apply a combination of the second and fourth options. That is, I will not consider Dr. Kanwal’s report as evidence that the chest x-ray evidence he reviewed was positive for coal workers’ pneumoconiosis. And, concerning probative value, since Dr. Kanwal’s diagnosis of pneumoconiosis and progressive massive pulmonary fibrosis is consistent with and supported by Dr. DePonte’s CT scan interpretation, which he had requested, I do not believe his additional consideration of the inadmissible chest x-rays adversely affects the probative value in terms of documentation for his diagnosis of coal workers’ pneumoconiosis and massive pulmonary fibrosis.

Dr. Smiddy

In his March 31, 2003 assessment, CX 5, Dr. Smiddy indicated that he reviewed a series of chest x-rays which indicated progressive upper changes consistent with progressive massive fibrosis. However, because Dr. Smiddy did not identify the sources of those radiographic studies, I determined that he had based his opinion of inadmissible chest x-ray evidence. In my assessment of Dr. Smiddy’s opinion, I noted that in reaching his determination, the physician had also relied in part on the admissible chest x-ray finding of complicated pneumoconiosis by Dr.

Thomas and the admissible CT scan interpretation of progressive massive fibrosis by Dr. DePonte.

The Board faulted my analysis because I “failed to complete” the 20 C.F.R. § 725.414 (a) (4) analysis. Specifically, I did not explain how I “was able to separate Dr. Smiddy’s diagnosis of complicated pneumoconiosis from the physician’s reliance of inadmissible x-ray readings.”

Hopefully, I now correct the Board’s noted deficiency and “complete” my 20 C.F.R. § 725.414 (a) (4) analysis by applying the *Harris* considerations to Dr. Smiddy’s evaluation. Again, I will utilize a combination of the second and fourth options set out in *Harris* by the BRB. That is, I will not consider Dr. Smiddy’s opinion that a series of chest x-rays showed development of progressive massive fibrosis. Concerning probative value, Dr. Smiddy had at least two admissible radiographic studies upon which he could have solely based his diagnosis of complicated coal workers’ pneumoconiosis. Further, in light of the present admissibility of his interpretation of the February 3, 2003 chest x-ray, Dr. Smiddy also relied on his admissible radiographic evaluation in determining the presence of complicated pneumoconiosis. As a result, regardless of his consideration of inadmissible chest x-rays, Dr. Smiddy had a remaining admissible documentary basis upon which to render a probative diagnosis of complicated pneumoconiosis.

Dr. Castle

In my initial adjudication, I determined that Dr. Castle’s assessment, DX 20, contained three inadmissible items of evidence: his interpretation of the August 1, 2001 chest x-ray, his interpretation of the April 2, 2001 CT scan, and his consideration of the radiographic record from Mr. Mullins’ prior black lung disability claims. Due to his reliance on a portion of that inadmissible evidence, in particular, his assessment of the chest x-ray and CT scan, I concluded Dr. Castle’s opinion on the presence of large pulmonary opacities had little probative value.

The Board considered my treatment of Dr. Castle’s medical opinion concerning consideration of inadmissible evidence to be inconsistent with my similar evaluation of the opinions by Dr. Kanwal and Dr. Smiddy, in which I considered their assessments probative even though they also considered inadmissible evidence. The Board further noted that though 20 C.F.R. § 725.414 did not contain a provision regarding the admissibility of medical evidence from prior claims, 20 C.F.R. § 725.309 (d) indicated such evidence was part of the record and therefore properly admissible.

In response, I first acknowledge my error associated with the medical evidence from Mr. Mullins’ prior claims. As directed by 20 C.F.R. § 725.309 (d), that medical evidence is admissible and thus does not provide a basis for diminishing the probative value of Dr. Castle’s opinion.²

²I believe this particular error was harmless since I did not use it as a basis for rejecting Dr. Castle’s opinion about complicated pneumoconiosis.

Turning the *Harris* considerations, and applying the second option, I again will not consider Dr. Castle's interpretation of the August 1, 2001 chest x-ray and the April 2, 2001 CT scan because they continue to be inadmissible.³

In addressing the fourth *Harris* option, and despite the Board's concern about my purported disparate assessment of the medical opinion, I continue to find that Dr. Castle's opinion regarding the absence of large pulmonary opacities and complicated pneumoconiosis has diminished probative value. I reach this seemingly disparate result because unlike the opinions of Dr. Kanwal and Dr. Smiddy, the inadmissible evidence that Dr. Castle relied upon was the sole basis for his conclusion regarding the absence of complicated pneumoconiosis.

Specifically, on August 1, 2001, Dr. Castle conducted a pulmonary evaluation of Mr. Mullins which included his interpretation of a chest x-ray in which he did not observe the presence of large pulmonary opacities. As part of his evaluation, Dr. Castle also interpreted the April 2, 2001 CT scan and similarly not find large opacities or complicated pneumoconiosis. Although he reviewed the medical evidence from the prior claims, the only other evidence from the present claim that Dr. Castle evaluated was Dr. Paranthaman's May 31, 2001 pulmonary examination, which included a chest x-ray finding of a large pulmonary opacity and a diagnosis of complicated pneumoconiosis. Due to the date of his evaluation, Dr. Castle was unaware of the subsequent,⁴ admissible interpretations of the August 1, 2001 chest x-ray by Dr. Wheeler and Dr. Scatarige, which indicated the absence of large opacities, and Dr. Wheeler's evaluation of the April 2, 2001 CT scan, showing the absence of complicated pneumoconiosis. Thus, while Dr. Kanwal and Dr. Smiddy reviewed both inadmissible and admissible evidence supporting their opinions on the issue of complicated pneumoconiosis, Dr. Castle only had his inadmissible chest x-ray and CT scan interpretations to support his finding that Mr. Mullins did not have complicated pneumoconiosis.

Summary

In light of the above comments, my adjudication of Mr. Mullins' claim is based on the hearing testimony and the documents admitted into evidence: DX 1 to DX 41 (with the exception of Dr. Scott's CT scan interpretation in DX 24), CX 1 to CX 8 and EX 1 to EX 4.⁵

³Instead of Dr. Castle's interpretation, the Employer elected the interpretations of Dr. Wheeler (EX 3) and Dr. Scatarige (DX 24), as its two, permissible, case-in-chief chest x-rays under 20 C.F.R. § 725.414 (a) (3) (i). Instead of Dr. Castle's evaluation, the Employer offered Dr. Wheeler interpretation of the April 2, 2001 CT scan as its one permissible rebuttal to Dr. Alexander's finding under 20 C.F.R. § 718.414 (a) (3) (ii).

⁴Dr. Wheeler and Dr. Scatarige rendered their assessments in March and April 2002.

⁵The following notations appear in this decision to identify exhibits: DX – Director exhibit; CX – Claimant exhibit; EX – Employer exhibit; ALJ – Administrative Law Judge exhibit; and TR – Transcript.

ISSUES ON REMAND

1. Whether, in filing a subsequent claim on April 9, 2001, Mr. Mullins has demonstrated that a change has occurred in one of the conditions, or elements, of entitlement, upon which the denial of his prior claim was based in June 1998.
2. If Mr. Mullins establishes a change in one of the applicable conditions of entitlement, whether he is entitled to benefits under the Act.

FINDINGS OF FACT AND CONCLUSIONS OF LAW

Stipulations of Fact

At the hearing, the parties stipulated to the following facts: a) Mr. Mullins was a coal miner with post-1969 coal mine employment; b) his length of coal mine employment was at least twenty-two years; and, c) Plowboy Coal Company is the responsible operator in this case (TR, pages 8 and 49).

Preliminary Findings⁶

Mr. Mullins was born on September 15, 1940. He first worked in the coal mines in 1960 and continued intermittently until his last coal mine employment in 1991. Mr. Mullins had to leave coal mining due to knee problems. In his last position as a coal miner, Mr. Mullins worked on the general maintenance of mines and belts where he cleaned and shoveled coal, installed belts, replaced rollers and serviced the head drives at the face of the mine. This work involved dragging, lifting, carrying and loading 50 pound bags of rock dust onto a machine. He also occasionally operated the shuttle car and scoop, which required him to crawl through the mines and lift heavy items while bent over (DX 1, DX 7, DX 9 and TR, pages 33 to 38).

Mr. Mullins began experiencing breathing problems around 1985 that presented as a productive cough and chest pain. Presently, he is unable to walk a short distance or climb stairs without stopping to catch his breath. Dr. Kanwal⁷ treats Mr. Mullins with breathing pills, cough syrup and inhalers to improve his condition. Mr. Mullins started smoking at 19 or 20 years old, smoking a pack and a half of cigarettes for 40 years until he stopped two and a half years ago. Mr. Mullins has not been gainfully employed since working in the coal mines in 1991 (TR, pages 38 to 40 and 42 to 46).

⁶The preliminary findings and modification principles are repeated directly from my May 17, 2004 decision and order.

⁷The transcript reflects the physician's name as being "Dr. Kimvall" (*see* TR, page 38), but the documents in the record indicate that Dr. Kanwal was Mr. Mullins' treating physician.

Issue # 1 – Change in Applicable Condition of Entitlement

Any time within one year of a denial or award of benefits, any party to the proceeding may request a reconsideration based on a change in condition or a mistake of fact made during the determination of the claim. 20 C.F.R. § 725.309 (c) and 20 C.F.R. § 725.310. However, after the expiration of one year, the submission of additional material or another claim is considered a subsequent claim which will be considered under the provisions of 20 C.F.R. § 725.309 (d). That subsequent claim will be denied unless the claimant can demonstrate that at least one of the conditions of entitlement upon which the prior claim was denied (“applicable condition of entitlement”) has changed and is now present. If a claimant does demonstrate a change in one of the applicable conditions of entitlement, then generally findings made in the prior claim(s) are not binding on the parties. 20 C.F.R. § 725.309 (d) (4). Consequently, the relevant inquiry in a subsequent claim is whether evidence developed since the prior adjudication would now support a finding of a previously denied condition of entitlement.

The court in *Peabody Coal Company v. Spese*, 117 F.3d 1001, 1008 (7th Cir. 1997) put the concept in clearer terms:

The key point is that the claimant cannot simply bring in new evidence that addresses his condition at the time of the earlier denial. His theory of recovery on the new claim must be consistent with the assumption that the original denial was correct. To prevail on the new claim, therefore, the miner must show that something capable of making a difference has changed since the record closed on the first application.

In adjudicating a subsequent claim by a living miner in which the applicable conditions of entitlement relate to the miner’s physical condition, I focus on the four basic conditions, or elements, a claimant must prove by preponderance of the evidence to receive black lung disability benefits under the Act. First, the miner must establish the presence of pneumoconiosis.⁸ Second, if a determination has been made that a miner has pneumoconiosis, it must be determined whether the miner’s pneumoconiosis arose, at least in part, out of coal mine employment.⁹ Third, the miner has to demonstrate he is totally disabled.¹⁰ And fourth, the miner must prove the total disability is due to pneumoconiosis.¹¹

With those four principle conditions of entitlement in mind, the next adjudication step requires the identification of the conditions of entitlement a claimant failed to prove in the prior claim. In that regard, of the four principle conditions of entitlement, the two elements that are usually capable of change are whether a miner has pneumoconiosis or whether he is totally disabled. *Lovilia Coal Co. v. Harvey*, 109 F.3d 445 (8th Cir. 1997). That is, the second element

⁸20 C.F.R. § 718.202.

⁹20 C.F.R. § 718.203 (a).

¹⁰20 C.F.R. § 718.204 (b).

¹¹20 C.F.R. § 718.204 (a).

of entitlement (pneumoconiosis arising out of coal mine employment) and the fourth element (total disability due to pneumoconiosis) require preliminary findings of the first element (presence of pneumoconiosis) and the third element (total disability).

In Mr. Mullins' case, his most recent, prior claim was finally denied in June 1998 for failure to prove total disability. Consequently, for purposes of adjudicating the present subsequent claim, I will evaluate the evidence developed since June 1998 to determine whether Mr. Mullins can now prove a total respiratory disability.

Total Disability

To receive black lung disability benefits under the Act, a claimant must have a total disability due to a respiratory impairment or pulmonary disease. If a coal miner suffers from complicated pneumoconiosis, there is an irrebuttable presumption of total disability. 20 C.F.R. §§ 718.204 (b) and 718.304. If that presumption does not apply, then according to the provisions of 20 C.F.R. §§ 718.204 (b) (1) and (2), in the absence of contrary evidence, total disability in a living miner's claim may be established by four methods: (i) pulmonary function tests; (ii) arterial blood-gas tests; (iii) a showing of cor pulmonale with right-sided, congestive heart failure; or (iv) a reasoned medical opinion demonstrating a coal miner, due to his pulmonary condition, is unable to return to his usual coal mine employment or engage in similar employment in the immediate area requiring similar skills.

While evaluating evidence regarding total disability, an administrative law judge must be cognizant of the fact that the total disability must be respiratory or pulmonary in nature. In *Beatty v. Danri Corp. & Triangle Enterprises and Dir.*, *OWCP*, 49 F.3d 993 (3d Cir. 1995), the court stated, in order to establish total disability due to pneumoconiosis, a miner must first prove that he suffers from a respiratory impairment that is totally disabling separate and apart from other non-respiratory conditions.

Mr. Mullins has not presented evidence of cor pulmonale with right-sided congestive heart failure. As a result, Mr. Mullins must demonstrate total respiratory or pulmonary disability through the presence of complicated pneumoconiosis, pulmonary function tests, arterial blood-gas tests, or medical opinion.

Complicated Pneumoconiosis

The regulation, in part, at 20 C.F.R. § 718.304, provides that if a claimant is able to establish the presence of complicated pneumoconiosis, then an irrebuttable presumption of total disability and death due to pneumoconiosis is established. In the Black Lung Benefits Act, 30 U.S.C. 921 (c) (3) (A) and (C), as implemented by 20 C.F.R. § 718.304 (a), Congress determined that if a miner suffered from a chronic dust disease of the lung which "when diagnosed by chest X-ray, yields one or more large opacities (greater than one centimeter in diameter) and would be classified in category A, B, or C," there shall be an irrebuttable presumption that his death was due to pneumoconiosis.¹² This type of large opacity is called "complicated pneumoconiosis."

¹²On the standard ILO chest x-ray classification worksheet, Form CM 933, large opacities are characterized by three sizes, identified by letters. Category A indicates the presence of a large opacity having a diameter greater than 10

The statute and regulation, 30 U.S.C. 921 (c) (3) (B) and (C) and 20 C.F.R. §§ 718.304 (b) and (c), also permit complicated pneumoconiosis to be established by either the presence of massive fibrosis in biopsy and autopsy evidence or other means which would be expected to produce equivalent results in chest x-rays or biopsy/autopsy evidence.

According to the U.S. Court of Appeals for the Fourth Circuit in *Eastern Associated Coal Corp. v. Director, OWCP [Scarbro]*, 220 F.3d 250 (4th Cir. 2000), the existence of complicated pneumoconiosis is established by “congressionally defined criteria.” As a result, the statute’s definition of complicated pneumoconiosis as radiographic evidence of one or more large opacities categorized as size A, B, or C, 30 U.S.C. 921 (c) (3) (A), represents the most objective measure of the condition. This sets the benchmark by which other methods for proving complicated pneumoconiosis are measured, as described in 30 U.S.C. 921 (c) (3) (B) and (C). *Id.* at 256. In other words, whether a massive lesion or other diagnostic results represent complicated pneumoconiosis under 30 U.S.C. 921 (c) (3) (B) and (C) requires an equivalency evaluation with the x-ray criteria set forth in 30 U.S.C. 921 (c) (3) (A).¹³ Additionally, the court emphasized that the legal definition of complicated pneumoconiosis as established by Congress controls over the medical community’s definition of the disease. *Id.* at 257. Finally, the court indicated that although all relevant and conflicting medical evidence must be considered and evaluated:

if the x-ray evidence vividly displays opacities exceeding one centimeter, its probative force is not reduced because the evidence under some other prong is inconclusive or less vivid. Instead, the x-ray evidence can lose force only if other evidence affirmatively shows that the opacities are not there or are not what they seem to be, perhaps because of an intervening pathology, some technical problem with equipment, or incompetence. *Id.*

Referencing a 1993 case from the U.S. Court of Appeals for the Fourth Circuit, *Lester v. Director, OWCP*, 993 F.2d 1143, 1145-46 (4th Cir. 1993) the Benefit Review Board in its remand emphasized that an administrative law judge “must weigh together all of the evidence relevant to the presence or absence of pneumoconiosis.” That mandate is consistent with other case law indicating that all evidence relevant to whether the miner has pneumoconiosis must be weighed. *Gray v. SLC Coal Co.*, 176 F.3d 382 (6th Cir. 1999), *Melnick v. Consolidation Coal Co.*, 16 B.L.R. 1-31 (1991); *Maypray v. Island Creek Coal Co.*, 7 B.L.R. 1-683 (1985).

In other words, even if the presence of large opacities has been established through one of the three methods set out in § 718.304, all other medical evidence must be considered and evaluated to determine whether the large opacities actually exist and involve pneumoconiosis. For example, the Benefits Review Board affirmed a finding of complicated pneumoconiosis under 20 C.F.R. §718.304 when the administrative law judge considered chest x-rays in

mm (one centimeter) but not more than 50 mm; or several large opacities, each greater than 10 mm but the diameter of the aggregate does not exceed 50 mm. Category B means an opacity, or opacities “larger or more numerous than Category A” whose combined area does not exceed the equivalent of the right upper zone of the lung. Category C represents one or more large opacities whose combined area exceeds the equivalent of the right upper zone.

¹³See also 20 C.F.R. §§ 718.304 (b) and (c).

conjunction with CT-scan findings to determine there was sufficient evidence to find complicated pneumoconiosis. *Keene v. G&A Coal Co.*, BRB No. 96-1689 BLA (Sept. 27, 1996). And, in another case, despite radiographic evidence of large opacities, the U.S. Court of Appeals for the Sixth Circuit upheld a determination that complicated pneumoconiosis did not exist based on probative autopsy evidence indicating the lesions were not complicated pneumoconiosis. *Gray*, 176 F.3d at 388.

In light of these statutory, regulatory and judicial principles, my present adjudication of whether a claimant is able to invoke the irrebuttable presumption under 20 C.F.R. § 718.304 involves a three step process.

First, I must determine whether: a) the preponderance of the chest x-rays establishes the presence of large opacities characterized by size as Category A, B, or C under recognized standards; or b) biopsy evidence shows massive fibrosis; or c) other diagnostic results exist which are equivalent to the requisite chest x-ray or biopsy evidence of large opacities.

Second, if large opacities are established through one means, I must also evaluate all the other relevant evidence in the record to determine whether it confirms or contradicts the presence of large opacities. In other words, I must assess whether the preponderance of the entire evidentiary record establishes the presence of large pulmonary opacities.

Third, if the preponderance of the evidence does demonstrate the existence of large opacities, I must then consider all other relevant evidence to determine whether that evidence contradicts or supports a finding that the large opacities are indicative of complicated pneumoconiosis.

1. Existence of Large Opacities

In the absence of biopsy evidence, Mr. Mullins must rely on chest x-ray imaging, or other medical tests or means to establish the presence of large opacities.

Chest X-Rays

Date of x-ray	Exhibit	Physician	Interpretation
May 31, 2001	DX 12	Dr. Paranthaman, B ¹⁴	Positive for pneumoconiosis, profusion 2/2, ¹⁵ type p/q opacities. ¹⁶ Large category A opacity of complicated pneumoconiosis present.

¹⁴The following designations apply: B – B reader, and BCR – Board Certified Radiologist. These designations indicate qualifications a person may possess to interpret x-ray film. A “B Reader” has demonstrated proficiency in assessing and classifying chest x-ray evidence for pneumoconiosis by successful completion of an examination. A “Board Certified Radiologist” has been certified, after four years of study and examination, as proficient in interpreting x-ray films of all kinds including images of the lungs. *See also* 20 C.F.R. § 718.202 (a) (1) (ii).

¹⁵The profusion (quantity) of the opacities (opaque spots) throughout the lungs is measured by four categories: 0 = small opacities are absent or so few they do not reach a category 1; 1 = small opacities definitely present but few in number; 2 = small opacities numerous but normal lung markings are still visible; and, 3 = small opacities very

(same)	DX 26	Dr. Wheeler, BCR, B	Negative for pneumoconiosis. Observed a “3 x 2 centimeter angular scar or mass” ¹⁷ in upper right lung, “possible tumor.” Small, irregular and nodular infiltrate or fibrosis compatible with TB or unknown activity and probably healed.” Possible emphysema present.
August 1, 2001	CX 1 & CX 4	Dr. Alexander, BCR, B	Positive for pneumoconiosis, profusion 2/1, type r/q opacities. 20 mm x 10 mm, category A large opacity in right upper lung present; could be cancer or complicated pneumoconiosis. Emphysema present.
(same)	EX 3	Dr. Wheeler, BCR, B	Negative for pneumoconiosis. Observed presence of 1.5 cm x 1 cm nodule in lower right upper lung, compatible with probably healed TB. Presence of mixed linear, irregular and small nodular infiltrate with probable small calcified granuloma or minimal adjacent linear fibrosis. Dr. Wheeler added, “check for surgery because well defined 5 and 6 cm masses in upper lobes were present on CT scan on 4/2/2001 and are now gone.”
(same)	DX 24	Dr. Scatarige, BCR, B	Negative for pneumoconiosis. Observed the presence of linear and nodular opacities that are probably tuberculosis. Probable emphysema present.
February 3, 2003	CX 1 & CX 2	Dr. Miller, BCR, B	Positive for pneumoconiosis, profusion category 2/2, type t/r opacities. Category A large opacities, greater than 10 cm, consistent with complicated pneumoconiosis present. Emphysema present.
(same)	EX 4	Dr. Wheeler, BCR, B	Negative for pneumoconiosis. Observed 2 cm mass or scar on right upper lung and 2 cm angular mass on right lower lung, compatible with healed inflammatory disease, possible granulomatous disease or tumor. Emphysema present.
(same)	CX 5 & 6	Dr. Smiddy	Positive for pneumoconiosis, profusion 2/2. Dense complicated pneumoconiosis present.

numerous and normal lung markings are usually partly or totally obscured. An interpretation of category 1, 2, or 3 means there are opacities in the lung which may be used as evidence of pneumoconiosis. If the interpretation is 0, then the assessment is not evidence of pneumoconiosis. A physician will usually list the interpretation with two digits. The first digit is the final assessment; the second digit represents the category that the doctor also seriously considered. For example, a reading of 1/2 means the doctor's final determination is category 1 opacities but he considered placing the interpretation in category 2. Additionally, according to 20 C.F.R. § 718.102 (b), a profusion reading of 0/1 does not constitute evidence of pneumoconiosis.

¹⁶There are two general categories of small opacities defined by their shape: rounded and irregular. Within those categories the opacities are further defined by size. The round opacities are: type p (less than 1.5 millimeter (mm) in diameter), type q (1.5 to 3.0 mm), and type r (3.0 to 10.0 mm). The irregular opacities are: type s (less than 1.5 mm), type t (1.5 to 3.0 mm) and type u (3.0 to 10.0 mm). JOHN CRAFTON & ANDREW DOUGLAS, RESPIRATORY DISEASES 581 (3d ed. 1981).

¹⁷I take judicial notice that as more radiation is absorbed by a dense object or mass, fewer x-rays will expose the radiographic film thus underexposing those areas such that they will appear as white or opaque. See radiographic course instruction by Dr. Matt Wright, board certified veterinarian radiologist, www.animalinsides.com/radphys/main.htm.

Of the three chest x-rays in the record, there is no dispute concerning two of the films. The May 31, 2001 film is positive for the presence of a large opacity. Although he found the film to be negative for pneumoconiosis, Dr. Wheeler nevertheless reported the presence of a large 3 by 2 centimeter mass, which appears as an opacity in the chest x-ray, in the pulmonary area of Mr. Mullins' chest. Dr. Paranthaman observed Category A large opacity as well. Therefore, the May 31, 2001 x-ray establishes the presence of a large opacity, greater than 1 cm.

The most recent chest x-ray of February 3, 2003 is also positive for the presence of a large opacity in Mr. Mullins' lungs because two of the three physicians who reviewed the film found the presence of pulmonary opacity greater than 1 cm. Though Dr. Smiddy indicated the presence of complicated pneumoconiosis, he did not provide a measurement for pulmonary opacity supporting his finding. However, Dr. Miller noted the presence of a category A large pulmonary opacity. Similarly, Dr. Wheeler described a nodule, again which appears as opacity on radiographic film, measuring up to 1.5 cm. As a result, the February 3, 2003 chest x-ray is positive for the existence of large opacities.

The remaining chest x-ray generated a medical dispute. In the August 1, 2001 film, Dr. Alexander observed a large opacity, measuring 20 mm (2 cm) by 10 mm (1 cm). Dr. Wheeler also identified a nodule, or radiographic opacity, measuring 1.5 cm x 1 cm, which represents a large opacity. In contrast, Dr. Scatarige did not identify the dimension of any of the observable opacities in the film, which I assume means he did not see a large opacity. Thus, his interpretation does not support a finding that a large opacity is present in the film. All three doctors who reviewed the film are dual qualified radiologists. Consequently, I find the consensus of Dr. Alexander and Dr. Wheeler that an opacity or nodule greater than 1 cm is present in Mr. Mullins' right upper lung represents the preponderance of the radiographic interpretations. Accordingly, I find the August 1, 2001 chest x-ray image contains the presence of a large opacity.

In summary, all three chest x-rays developed since Mr. Mullins filed his present claim contain evidence of a pulmonary opacity greater than 1 cm. Consequently, Mr. Mullins has definitively established the presence of a large opacity in his lungs through chest x-rays which is a requirement of 20 C.F.R. § 718.304 (a) for the invocation of the irrebuttable presumption of total disability due to pneumoconiosis.

2. Other Evidence of Large Opacities

Although the preponderance of chest x-rays establishes the presence of a large pulmonary opacity, I must assess the other relevant evidence to determine whether it confirms or negates the radiographic finding of a large pulmonary opacity. In Mr. Mullins' case, that potentially relevant evidence consists of interpretations of an April 2, 2001 CT scan.

Dr. Michael S. Alexander, a B reader and board certified radiologist, read the CT scan taken of Mr. Mullins on April 2, 2001, DX 18. He observed emphysematous changes and a background of innumerable small (2 to 6 mm) round opacities in both lungs, moderate profusion, which were consistent with coal workers' pneumoconiosis. Bilaterally, in both upper zones, Dr. Alexander found "conglomerate fibrotic masses indicative of complicated pneumoconiosis."

The fibrotic mass in the right upper zone was 60 mm in length; the left upper zones fibrotic mass measured 47 mm. Both large masses meet the criteria for Category B complicated pneumoconiosis. Areas of calcification were present in portions of the masses. Dr. Alexander diagnosed Category B complicated pneumoconiosis; moderate profusion of small pneumoconiotic nodules with areas of coalescence; and emphysema.

When Dr. Katherine A. DePonte, a B reader and board certified radiologist, interpreted the April 2, 2001 CT scan, she also found severe centrilobular and bullous emphysema, DX 18. The radiologist also reported the presence of progressive massive fibrosis consisting of small round opacities, particularly in the upper zones and bilateral conglomerate masses with areas of calcification. Dr. DePonte diagnosed severe pneumoconiosis with progressive massive fibrosis; bullous emphysema; and centrilobular emphysema.

Dr. Paul S. Wheeler, a B reader and board certified radiologist, also read Mr. Mullins April 2001 CT scan, EX 2. He observed a 6 by 3 centimeter mass in the right upper lung and 5 by 2 centimeter mass on the left upper lung with calcified granulomata and linear scars, compatible with "conglomerate TB." He also observed the presence of calcified granulomata in subcarinal and bilateral hilar nodes compatible with healed TB and histoplasmosis. Dr. Wheeler noted the presence of subtle tiny nodule infiltrates in the center and upper lungs compatible with coal workers' pneumoconiosis "and/or TB." However, the profusion of the small nodules "is not enough to give large opacities of cwp." Dr. Wheeler's final diagnosis was probable, healed TB with thin conglomerate masses containing calcified granulomata in the upper lungs, moderate emphysema and minimal TB or CWP with tiny nodules in the central and upper portion, with an amount of profusion too low to cause larger opacities.

The CT scan process presents a sectional view of a person's lungs. Two of the three radiologists who reviewed these sectional images noted the presence of large focal scars, masses, or conglomerate masses bilaterally in the lungs' upper zones. Specifically, Dr. Alexander and Dr. Wheeler presented remarkably similar measurements (at least in one dimension) for the mass in the right upper lung, with readings of 6 cm in length, 6 cm x 1.3 cm, and 6 cm x 3 cm respectively. These CT interpretations clearly reinforce the chest x-ray evidence and confirm the presence of large pulmonary opacities in Mr. Mullins' lungs.

3. Cause, or Etiology, of Large Opacities

Through radiographic evidence, as supported by the April 2001 CT scan, Mr. Mullins has proven the existence of large pulmonary opacities. As a result, I move to the third adjudicative step and consider other relevant medical evidence on the cause of the opacities prior to making a determination of whether Mr. Mullins has invoked the 20 C.F.R. § 718.304 irrebuttable presumption for complicated pneumoconiosis. At this point, I consider all other medical evidence to determine whether the large pulmonary opacities are due to coal dust exposure or coal workers' pneumoconiosis. In Mr. Mullins' case, this "other" medical evidence has four components: a) other objective medical test results; b) medical opinion; c) CT scan comments; and d) comments by physicians who evaluated his chest x-rays.

Objective Medical Test Results

Pulmonary Function Tests

Exhibit	Date / Doctor	Age / Height	FEV ¹ pre ¹⁸ post ¹⁹	FVC pre post	MVV pre post	% FEV ¹ / FVC pre post	Qualified ²⁰ pre Post	Comments
DX 12	May 31, 2001 Dr. Paranthaman	60 67.0"	2.61 2.78	4.72 4.80	140 147	55.3% 57.9%	No ²¹ No	
DX 20	August 1, 2001 Dr. Castle	60 68.0"	2.45 2.32	3.98 3.67		61.6% 63.2%	No ²² No	Mild airway obstruction
CX 5, CX 6, & EX 5	Feb. 28, 2003 Dr. Smiddy	62 69.0"	2.38	4.34		55.3%	No ²³	Severe obstructive defect

Arterial Blood Gas Studies

Exhibit	Date / Doctor	pCO ² (rest) pCO ² (exercise)	pO ² (rest) pO ² (exercise)	Qualified ²⁴	Comments
DX 12	May 31, 2001 Dr. Paranthaman	30	75	No ²⁵	Mild hypoxemia
DX 10	August 1, 2001 Dr. Castle	31.8	81.8	No ²⁶	

¹⁸Test result before administration of a bronchodilator.

¹⁹Test result following administration of a bronchodilator.

²⁰Under 20 C.F.R. § 718.204 (b) (2) (i), to qualify for total disability based on pulmonary function tests, for a miner's age and height, the FEV1 must be equal to or less than the value in Appendix B, Table B1 of 20 C.F.R. § 718, **and either** the FVC has to be equal or less than the value in Table B3, or the MVV has to be equal **or** less than the value in Table B5, or the ratio FEV1/FVC has to be equal to or less than 55%.

²¹The qualifying FEV1 number is 1.81 for age 60 and 66.9"; the corresponding qualifying FVC and MVV values are 2.31 and 72, respectively.

²²The qualifying FEV1 number is 1.90 for age 60 and 68.1"; the corresponding qualifying FVC and MVV values are 2.43 and 76, respectively.

²³The qualifying FEV1 number is 1.93 for age 62 and 68.9"; the corresponding qualifying FVC and MVV values are 2.47 and 77, respectively.

²⁴To qualify for Federal Black Lung Disability benefits at a coal miner's given pCO² level, the value of the coal miner's pO² must be equal to or less than corresponding pO² value listed in the Blood Gas Tables in Appendix C for 20 C.F.R. § 718.

²⁵For the pCO² of 30, the qualifying pO² is 70, or less.

²⁶For the pCO² of 32, the qualifying pO² is 68, or less.

TB Tests

Dr. Kanwal reported that Mr. Mullins' tuberculosis tests on March 26, 2002 and June 3, 2003 were negative (DX 25 and CX 7).

Discussion

In general, the objective medical test evidence demonstrates Mr. Mullins does not have a significant totally disabling pulmonary impairment. Additionally, most of the physicians to evaluate that data, with the exception of Dr. Smiddy, agreed the test results did not show a total respiratory impairment. However, the absence of other objective medical evidence showing a total respiratory disability does not prevent invoking the presumption under 20 C.F.R. § 718.304 or impeach a finding of complicated pneumoconiosis. The *Scarbro* court emphasized that the statutory scheme does not set out complicated pneumoconiosis in medical terms. Instead, the invocation is based on the radiographic evidence of large, categorized opacities. Further, since the presumption of total disability is irrebuttable, the existence of objective medical evidence to the contrary is not particularly relevant unless that evidence also shows the large opacities are not what they seem to be. Standing alone, Mr. Mullin's non-qualifying pulmonary function tests and blood gas studies, which do not specifically isolate the cause of a pulmonary impairment, do not provide sufficient evidence to determine the pathology associated with the large opacities in Mr. Mullins' lungs.

In contrast, the two negative TB tests provide probative information that the large pulmonary opacities may not be related to healed tuberculosis.

Medical Opinion

Dr. S. K. Paranthaman
DX 12

On May 31, 2001, Dr. Paranthaman, board certified in pulmonary disease and internal medicine,²⁷ conducted a pulmonary evaluation of Mr. Mullins who reported productive cough, wheezing, and shortness of breath on exertion. Mr. Mullins has a coal mine employment history of 25 years. He smoked a pack of cigarettes per day for 25 years, stopping one year before the examination. In the chest x-ray, Dr. Paranthaman observed coal workers' pneumoconiosis and large opacities. The pulmonary function test was normal and the arterial blood gas study revealed mild hypoxemia. Based on the radiographic evidence of large opacities, Dr. Paranthaman diagnosed complicated pneumoconiosis which was totally disabling. He also believed Mr. Mullins had chronic bronchitis due to smoking and coal dust exposure which caused a mild functional impairment. An arthritic knee prevented Mr. Mullins from engaging in heavy manual labor.

²⁷As set out in my initial decision and order, I have take judicial notice of Dr. Paranthaman's board certification.

Dr. James Castle
DX 20

On August 15, 2001, Dr. Castle, board certified in internal medicine and pulmonary diseases, conducted a pulmonary evaluation of Mr. Mullins who reported shortness of breath and productive cough over the past 10 to 12 years. Mr. Mullins also indicated that he wheezed and experienced chest discomfort. Mr. Mullins was diagnosed with pneumonia in 1995 when he was hospitalized. He has no history of asthma or TB. Mr. Mullins was a smoker of a pack and-a-half of cigarettes per day from the age of 25 through a year and a half prior to the examination, when he was 62 years old, giving him a 35 pack year²⁸ history. Mr. Mullins used an inhaler and was taking breathing pills to improve his breathing condition. He worked in the coal mines for 25 years. His last coal mine employment occurred in 1991.

Upon physical examination, the chest was normal. The pulmonary function test indicated a mild airway obstruction. The blood gas study was normal. Based on his interpretations of a chest x-ray and the April 2, 2001 CT scan,²⁹ Dr. Castle diagnosed simple coal workers' pneumoconiosis but did not find evidence of complicated pneumoconiosis. Additionally, he noted pulmonary emphysema caused by cigarette smoking. This pulmonary condition caused a mild airway obstruction, which did not render Mr. Mullins totally disabled from a respiratory standpoint.

Dr. Castle also reviewed the medical record from Mr. Mullins' prior black lung claims and the February 2001 pulmonary examination by Dr. Paranthaman. The additional review did not alter his opinion. While Mr. Mullins had simple pneumoconiosis and a mild impairment, Dr. Castle emphasized that the April 2, 2001 CT scan did not show the presence of complicated pneumoconiosis.

Dr. Joseph Smiddy
CX 5 and CX 6

On March 31, 2003, Dr. Joseph F. Smiddy, board certified in internal medicine, conducted a pulmonary evaluation of Mr. Mullins who reported productive cough, shortness of breath, and wheezing. Mr. Mullins had a history of complicated pneumoconiosis, emphysema and pneumoconiosis. He was taking medication to aid his breathing. Mr. Mullins worked in the coal mines for 23 years and experienced heavy exposure to coal dust and some exposure to rock dust. He last worked in the coal mines in 1991. Mr. Mullins smoked cigarettes from the age of 21 to 59.

Upon physical examination, the chest was normal. Dr. Smiddy reviewed Mr. Mullins' most recent chest x-ray reading by Dr. Miller and agreed with the radiologist's finding that Mr. Mullins has dense complicated pneumoconiosis with multiple pneumoconiotic nodules. He also reviewed Dr. DePonte's reading of the April 2001 CT scan which showed severe pneumoconiosis and progressive massive fibrosis. Moreover, considering Mr. Mullins was using

²⁸A pack year equals the consumption of one pack of cigarettes per day for one year.

²⁹As previously discussed, Dr. Castle's interpretations are inadmissible.

bronchodilator therapy, Dr. Smiddy concluded the results of the February 2003 pulmonary function test showed a severe obstructive ventilatory defect. Dr. Smiddy believed Mr. Mullins has an obstructive defect that renders him one-hundred percent totally disabled; he is unable to return to coal mining. The physician prescribed continued bronchodilator therapy.

Dr. Kanwal
DX 25, CX 7, and CX 8

On April 15, 2002, Dr. G. S. Kanwal stated he had treated Mr. Mullins' pulmonary problems since 1994. Mr. Mullins reported a history of shortness of breath and cough. He worked in the coal mines for 25 years, ending his coal mine employment in 1991. Dr. Kanwal noted that a TB test taken on March 26, 2002 was negative for the presence of TB. Based on Mr. Mullins' x-rays and CT scan, Dr. Kanwal believed Mr. Mullins had coal workers' pneumoconiosis and "has developed massive pul. fibrosis interstitial." Mr. Mullins pulmonary condition was related to his former coal miner occupation. Dr. Kanwal administered a second test for tuberculosis on June 3, 2003; the result was negative.

Discussion

The physicians who considered Mr. Mullins' lung condition disagree on whether he has complicated pneumoconiosis. Dr. Paranthaman, a board certified pulmonologist, diagnosed Mr. Mullins with complicated pneumoconiosis, noting category A opacities. Dr. Smiddy found "severe pneumoconiosis with progressive massive fibrosis." This diagnosis is consistent with a finding of complicated pneumoconiosis. Notably, the Supreme Court recognized complicated pneumoconiosis as "involv[ing] progressive massive fibrosis as a complex reaction to dust and other factors." *Usery v. Turner Elkhorn Mining Co.*, 428 U.S. 1, 7 (1976). Moreover, the Fourth Circuit commented that complicated pneumoconiosis is also known "by its more dauntingly descriptive name, 'progressive massive fibrosis'." *Lisa Lee Mines v. Director, OWCP*, 86 F.3d 1358, 1359 (4th Cir. 1996). For that reason, Dr. Smiddy's medical opinion essentially represents a diagnosis of complicated pneumoconiosis and is therefore consistent with the radiographic evidence as well. In a similar manner, Dr. Kanwal diagnosed Mr. Mullins with "coal workers' pneumoconiosis with massive pulmonary fibrosis interstitial," also rendering a complicated pneumoconiosis diagnosis.

Only Dr. Castle, another board certified pulmonologist, opined that Mr. Mullins does not have complicated pneumoconiosis in light of the radiographic evidence and pulmonary test results. However, Dr. Castle based a significant portion of his conclusion on his two inadmissible interpretations of the August 1, 2001 chest x-ray and the April 2, 2001 CT scan, which causes his opinion to lose probative value. Dr. Castle also emphasized that the pulmonary evaluations indicate Mr. Mullins is not totally disabled and suffers from only a mild impairment. As previously discussed, whether or not other medical tests demonstrate that Mr. Mullins is totally disabled from a respiratory standpoint does not provide sufficient contrary evidence that the large opacities in Mr. Mullins' lungs are not related to complicated pneumoconiosis. In other words, the absence of a demonstrable pulmonary impairment does not preclude a finding of complicated pneumoconiosis under the statutory definition of the disease in terms of large pulmonary opacities.

In summary, on the issue of complicated pneumoconiosis, Dr. Castle's opinion has little probative value. On the other hand, Dr. Paranthaman, Dr. Kanwal, and Dr. Smiddy presented probative opinions indicating Mr. Mullins has complicated pneumoconiosis. The consensus of these three physicians represents the preponderance of the more probative medical opinion. Consequently, the preponderance of the more probative medical opinion supports a finding that the large pulmonary opacities in Mr. Mullins' chest involve complicated pneumoconiosis.

CT Scan Comments

Concerning the source of the large pulmonary opacities, the medical experts who evaluated the April 2, 2001 CT scan are in disagreement. Dr. Alexander diagnosed his findings as complicated pneumoconiosis. Reaching a similar conclusion, Dr. DePonte indicated Mr. Mullins has progressive massive fibrosis associated with coal workers' pneumoconiosis, which equates to a finding of complicated pneumoconiosis. However, Dr. Wheeler believed the cause of the lung mass and scarring was "healed TB."

In assessing the respective probative value of these three assessments, I first note that all three radiologists presented straight forward assessments of the sectional slices of the CT imaging. However, for two reasoning issues, I believe Dr. Wheeler's assessment loses some probative value. First, Dr. Wheeler concluded the masses were not complicated pneumoconiosis because the noted underlying profusion of simple coal workers' pneumoconiosis was insufficient to cause complicated pneumoconiosis. In other words, Dr. Wheeler appears to require the presence of extensive coal workers' pneumoconiosis as a prerequisite for a diagnosis of complicated pneumoconiosis. However, as previously discussed, the *Scarbro* court emphasized that complicated pneumoconiosis under the Act was not necessarily the same as medical complicated pneumoconiosis. Second, in concluding that pulmonary masses were associated with healed tuberculosis, Dr. Wheeler did not reconcile his diagnosis with other medical evidence in the record consisting of two tests for tuberculosis administered on March 26, 2002 and June 3, 2003 by Dr. Kanwal which were negative. Specifically, Dr. Wheeler did not subsequently address whether the March 2002 and June 2003 negative TB tests would alter his etiology opinion.³⁰ At a minimum, these two negative tests call into question the viability of Dr. Wheeler's conclusion that the pulmonary masses were healed tuberculosis.³¹

I have considered that when Dr. Alexander interpreted the August 2001 chest x-ray in March 2003, about two years after his May 2001 review of the April 2001 CT scan, he indicated the Category A opacity could be either complicated pneumoconiosis or lung cancer. That equivocal diagnosis is less certain than his definitive finding of complicated pneumoconiosis in

³⁰In his closing brief, page 7, counsel for the Employer stated, "While the claimant has submitted fairly recent reports from Dr. Kanwal suggesting the claimant does not have active TB at the time the testing was done, this is certainly not the same thing as a doctor saying the claimant has never had TB." In response to his assertion, I note that no physician in the record addressed whether a TB test was indicative of only active TB. One medical book, THE MERCK MANUAL 116 (13th ed. 1977), indicates that a reaction to tuberculin test is diagnostic of tuberculosis infection, though not necessarily of *active* TB (emphasis in the original text).

³¹In footnote 5 of its remand decision, the Benefits Review Board determined that I acted within my discretion to assign less probative value to Dr. Wheeler's diagnosis he did not indicate the effect the negative tuberculosis tests might have on his conclusion.

his earlier CT evaluation. However, I conclude that Dr. Alexander's uncertainty in reviewing the chest x-ray two years after he evaluated the CT scan does not adversely affect the evidentiary value of his CT scan findings. A CT scan and chest x-ray are different analytical tools for assessing pulmonary condition with potentially varying degrees of accuracy. Dr. Alexander's hesitancy about the chest x-ray image may simply reflect the differences in the two diagnostic tools. Significantly, the March 2003 x-ray report does not indicate that Dr. Alexander also reconsidered his earlier CT scan diagnosis and thereby changed his mind about the CT images.

In summary, Dr. Wheeler's CT scan etiology finding has diminished probative value. Whereas, the probative consensus of Dr. DePonte and Dr. Alexander concerning the April 2, 2001 CT scan indicates the presence of severe pneumoconiosis associated with progressive massive pulmonary fibrosis and complicated pneumoconiosis. Accordingly, I find the preponderance of the probative CT scan comments establishes that the large pulmonary opacities are attributable to complicated pneumoconiosis.

X-Ray Comments

With the sole exception of Dr. Scatarige, all the radiologists and physicians who reviewed Mr. Mullins' chest x-rays observed large pulmonary opacities, masses, and nodules. At the same time, they disagreed on the etiology of these opacities.

Dr. Paranthaman, Dr. Miller, a dual qualified radiologist, and Dr. Smiddy believed the large pulmonary opacities were consistent with complicated pneumoconiosis. Their definitive and certain findings have probative value.

When Dr. Wheeler, a dual qualified radiologist, reviewed the May 31, 2001 chest x-ray, he concluded the large, 3 cm x 2 cm mass was not complicated pneumoconiosis; instead, it was a "possible" tumor. In his interpretation of the August 1, 2001 chest x-ray, while again finding the large opacity inconsistent with complicated pneumoconiosis, Dr. Wheeler dropped his tumor diagnosis and indicated the identified large mass was "probably healed TB." In his evaluation of the February 3, 2003 chest film, Dr. Wheeler rejected complicated pneumoconiosis as an etiology and suggested the large opacities he observed were now due to either a healed inflammatory disease, granulomatous disease, or tumor. While Dr. Wheeler clearly believed Mr. Mullins' large pulmonary opacity was not complicated pneumoconiosis, his alternative diagnoses of a possible tumor and healed TB have diminished probative value for two reasons. First, as previously discussed, when he presented tuberculosis as a possible cause, Dr. Wheeler did not address the two negative TB tests. Second, whereas the chest x-rays and CT scans establish the presence of pneumoconiosis, the medical record does not contain any other objective evidence that the large pulmonary masses are associated with tumors or cancer.

Finally, Dr. Alexander was not sure of the cause indicating the pulmonary opacity could be either complicated pneumoconiosis or cancer. By presenting alternative diagnoses of either complicated pneumoconiosis or cancer, Dr. Alexander has essentially presented an equivocal and less probative finding.

In light of the diminished probative value of Dr. Alexander's assessment, and considering the diminished probative value of Dr. Wheeler's alternative etiology diagnoses, I find the consensus of Dr. Paranthaman, Dr. Miller and Dr. Smiddy represents the preponderance of the more probative evidence and establishes that the large pulmonary opacities are consistent with complicated pneumoconiosis.

Finally, to the extent that Dr. Wheeler's negative finding of complicated pneumoconiosis, standing alone, does not have diminished probative value, his finding is offset by the equally probative opinion by Dr. Miller. As dual qualified radiologists, both Dr. Wheeler and Dr. Miller were best qualified to present the more probative comments. Their contrary professional opinions stand in equipoise. Such an evidentiary equilibrium would not preclude a finding that the large pulmonary opacities are due complicated pneumoconiosis based on other medical evidence in the record, such as CT scan comments and medical opinion.

Conclusion

The most recent chest x-rays, and an April 2001 CT scan, establish the presence of large pulmonary opacities. Upon consideration of the remaining medical evidence associated with Mr. Mullins' present claim, I find the more probative physician opinions and CT scan comments establish that the large pulmonary opacities are complicated pneumoconiosis. The inconclusive pulmonary tests and equipoise chest x-ray comments do not provide contrary evidence. Accordingly, I conclude Mr. Mullins is able to invoke the presumption under 20 C.F.R. § 718.304 through a) the presence of large pulmonary opacities in the May 31, 2001, August 1, 2001, and February 3, 2003 chest x-rays, as confirmed by the April 2, 2001 CT scan; and, b) more probative medical opinion and CT scan comments that establish the large pulmonary opacities represent complicated pneumoconiosis.

Through the invocation under 20 C.F.R. § 718.304, Mr. Mullins has proven that he is totally disabled due to pneumoconiosis, thereby establishing that one of the conditions of entitlement that he previously failed to prove (total disability) has changed and is now present. As a result, under 20 C.F.R. § 725.309, I must now examine the entire medical record to determine whether Mr. Mullins is entitled to black lung disability benefits.

Issue # 2 – Entitlement to Benefits

As previously discussed, to receive benefits under the Act, Mr. Mullins must prove that he has a) pneumoconiosis b) that arose out of his coal mine employment and that he is c) totally disabled d) due to coal workers' pneumoconiosis.

Pneumoconiosis

"Pneumoconiosis" is defined as a chronic dust disease arising out of coal mine employment.³² The regulatory definitions include both clinical, or medical pneumoconiosis, defined as diseases recognized by the medical community as pneumoconiosis, and legal

³²20 C.F.R. § 718.201 (a).

pneumoconiosis, defined as “any chronic lung disease arising out of coal mine employment.”³³ The regulation further indicates that a lung disease arising out of coal mine employment includes “any chronic pulmonary disease or respiratory or pulmonary impairment significantly related to, or substantially aggravated by, dust exposure in coal mine employment.” 20 C.F.R. § 718.201 (b). As courts have noted, under the Act, the legal definition of pneumoconiosis is much broader than medical pneumoconiosis. *Kline v. Director, OWCP*, 877 F.2d 1175 (3d Cir. 1989).

According to 20 C.F.R. § 718.202, the existence of pneumoconiosis may be established by four methods: chest x-ray (§ 718.202 (a) (1)), autopsy or biopsy report (§ 718.202 (a) (2)), regulatory presumption (§ 718.202 (a) (3)), and medical opinion (§ 718.202 (a) (4)). One of the regulatory presumptions specified by 20 C.F.R. § 718.203 (a) (3) is the irrebuttable presumption under 20 C.F.R. § 718.304, relating to the presence of complicated pneumoconiosis. Since Mr. Mullins has now invoked that presumption of total disability due to pneumoconiosis, he has proven the presence of pneumoconiosis under 20 C.F.R. § 718.202 (a) (3).

According to the U.S. Court of Appeals in *Island Creek Coal Co. v. Compton*, 211 F.3d 203 (4th Cir. 2000), on the issue of pneumoconiosis, I must consider all the chest x-ray evidence and medical opinion together to determine whether a claimant can establish pneumoconiosis. Since my determination on the issue of the presence of complicated pneumoconiosis required consideration of the medical record in the present claim, including chest x-rays, CT scans, pulmonary testing, and medical opinion, I believe the *Compton* evidentiary considerations requirement have also been satisfied. Further, my review of the earlier medical evidence in the prior claims provided little relevant contrary information on the present state of Mr. Mullins’ pulmonary condition – complicated pneumoconiosis.

Pneumoconiosis Arising Out of Coal Mine Employment

Having proven the presence of pneumoconiosis, Mr. Mullins must next establish that his pneumoconiosis arose, at least in part, out of coal mine employment. According to 20 C.F.R. § 718.203 (b), if a miner who is suffering from pneumoconiosis was employed for ten years or more in one or more coal mines, there is a rebuttable presumption that pneumoconiosis arose out of such employment. As the parties stipulated, Mr. Mullins has at least 22 years of coal mine employment. As a result, he is entitled to the regulatory presumption.

Because the presumption of pneumoconiosis arising out of coal mine employment is rebuttable, I must reexamine the medical record to determine whether sufficient evidence exists to sever the presumptive connection between Mr. Mullins’ pneumoconiosis and his coal mine employment. The medical evidence contained in the earlier three claims provides little relevant information on whether the pneumoconiosis which Mr. Mullins has now developed is due to some cause other than coal mining. In the present claim, the x-ray and CT scan comments by Dr. Wheeler suggest other causes for the presence of the large pulmonary opacities. However, I have already determined that his opinion does not establish a non-coal dust related pathology. As a result, the causation presumption under 20 C.F.R. § 718.203 (b) has not been rebutted and

³³20 C.F.R. § 718.201 (a) (1) and (2).

Mr. Mullins' pneumoconiosis is due to his coal mine employment. Mr. Mullins has proven that he has coal workers' pneumoconiosis.

Total Disability and Total Disability Due to Pneumoconiosis

The last two requisite elements of entitlement are total disability and total disability due to coal workers' pneumoconiosis. Having invoked the 20 C.F.R. § 718.304 irrebuttable presumption and established causation under 20 C.F.R. §718.203 (b), Mr. Mullins has also established these two necessary components for receipt of benefits under the Act.

CONCLUSION

Based on the presence of large opacities in the three most recent chest x-rays and a CT scan, and the preponderance of the more probative medical opinion and CT scan comments, Mr. Mullins has invoked the irrebuttable presumption of total disability due to pneumoconiosis under 20 C.F.R. § 718.304. That invocation also establishes the presence of pneumoconiosis under 20 C.F.R. § 718.202 (a) (3). Finally, through the presumption in 20 C.F.R. § 718.203 (b), with at least 22 years of coal mine employment, Mr. Mullins is able to establish that his pneumoconiosis was due to his coal mine employment. Having proved each requisite element of entitlement, Mr. Mullins has met his burden of proof and his claim must be approved.

Date of Entitlement

Under 20 C.F.R. § 725.503 (b) in the case of a coal miner who is totally disabled due to pneumoconiosis, benefits are payable from the month of onset of total disability. When the evidence does not establish when the onset of total disability occurred, then benefits are payable starting the month the claim was filed. The BRB has placed the burden on the miner to demonstrate the onset of total disability. *Johnson v. Director, OWCP*, 1 B.L.R. 1-600 (1978). Placing that burden on the claimant makes sense, especially if the miner believes his total disability arose prior to the date he filed his claim. In that case, failure to prove a date of onset earlier than the date of the claim means the claimant receives benefits only from the date the claim was filed. The BRB also stated in *Johnson*, "[c]learly the date of filing is the preferred date of onset unless evidence to the contrary is presented."

At the same time, a miner may not receive benefits for the period of time after the claim filing date during which he was not totally disabled. *Lykins v. Director, OWCP*, 12 B.L.R. 1-181, 1-183 (1989). This principle may come into play if evidence indicates there was a period of time after the filing of the claim during which the miner was not totally disabled. One example is the situation in *Rochester and Pittsburgh Coal Co. v. Krecota*, 868 F.2d 600 (3d Cir. 1989) where after the miner filed his claim, the initial probative medical opinions provided some evidence that the miner was not totally disabled, yet the administrative law judge found a subsequent evaluation did establish total disability and then set the entitlement date as the date of the claim. The appellate court affirmed the finding of total disability but believed the administrative law judge erred by awarding benefits from the date of the claim because he had not considered whether the earlier medical evaluations indicated that the pneumoconiosis had not yet progressed to a totally disabling stage. In other words, if evidence shows an identifiable

period of time where a miner was not totally disabled by pneumoconiosis that is subsequent to the date the miner filed his claim and prior to a firm medical determination of total disability, then it is inappropriate to award benefits from the month the claim was filed.

However, if no intervening medical evidence raises the possibility of total disability not being present between the claim filing date and the first medical evaluation establishing total disability, then a different set of principles is applicable. In this situation, when the first medical examination after the claim is filed leads to a finding of total disability, the date of the examination does not necessarily establish the month of onset of total disability. Instead, it only indicates that some time prior to the exam, the miner became totally disabled. *See Tobrey v. Director, OWCP*, 7 B.L.R. 1-407, 1-409 (1985) (the date the claimant is “first able to muster evidence of total disability is not necessarily the date of onset”).

Mr. Mullins has not presented definitive chest x-ray evidence or other medical evidence showing that the onset of his total disability occurred before April 9, 2001, when he filed his claim. The first chest x-ray to establish the presence of large opacities, which in turn invoked the presumption of total disability due to pneumoconiosis, was obtained the next month on May 31, 2001. Since there is no showing Mr. Mullins was not totally disabled in the month between the claim filing date and the chest x-ray, his black lung disability benefits are payable beginning April 1, 2001.³⁴

³⁴I note that the April 2, 2001 CT scan revealed the presence of a large opacity. However, chest x-ray evidence, rather than the CT scan, was the triggering mechanism for invoking the total disability presumption. Additionally, even if the CT scan were used to establish the date of onset, the date of entitlement would still remain April 1, 2001.

ORDER

The claim of MR. MORELLE MULLINS for benefits under the Act is **GRANTED**. PLOWBOY COAL COMPANY and CONTINENTAL INDEMNITY COMPANY are ordered to:

1. Pay Mr. Morelle Mullins all benefits to which he is entitled under the Act and Regulations. Benefits shall commence April 1, 2001;
2. Reimburse the Black Lung Disability Trust Fund, pursuant to 20 C.F.R. § 725.602 (a), for all interim payments made by the Black Lung Disability Trust Fund to Mr. Morelle Mullins;
3. Deduct from the payments ordered in paragraph one, as appropriate, the amounts reimbursed to the Black Lung Disability Trust Fund as directed in paragraph two; and
4. Pay to the Secretary of Labor interest as required pursuant to 20 C.F.R. § 725.608 (b).

SO ORDERED:

A

RICHARD T. STANSELL-GAMM
Administrative Law Judge

Date Signed: July 27, 2006
Washington, DC

NOTICE OF APPEAL RIGHTS: If you are dissatisfied with the administrative law judge's decision, you may file an appeal with the Benefits Review Board ("Board"). To be timely, your appeal must be filed with the Board within thirty (30) days from the date on which the administrative law judge's decision is filed with the district director's office. See 20 C.F.R. §§ 725.458 and 725.459. The address of the Board is: Benefits Review Board, U.S. Department of Labor, P.O. Box 37601, Washington, DC 20013-7601. Your appeal is considered filed on the date it is received in the Office of the Clerk of the Board, unless the appeal is sent by mail and the Board determines that the U.S. Postal Service postmark, or other reliable evidence establishing the mailing date, may be used. See 20 C.F.R. § 802.207. Once an appeal is filed, all inquiries and correspondence should be directed to the Board. After receipt of an appeal, the Board will issue a notice to all parties acknowledging receipt of the appeal and advising them as to any further action needed. At the time you file an appeal with the Board, you must also send a copy of the appeal letter to Allen Feldman, Associate Solicitor, Black Lung and Longshore Legal Services, U.S. Department of Labor, 200 Constitution Ave., NW, Room N-2117, Washington, DC 20210. See 20 C.F.R. § 725.481. If an appeal is not timely filed with the Board, the administrative law judge's decision becomes the final order of the Secretary of Labor pursuant to 20 C.F.R. § 725.479(a).]